IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICUS CURIAE MOTOR VEHICLE MANUFACTURERS ASSOCIATION OF THE UNITED STATES, INC.

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All parties have consented to the filing of this brief for amicus curiae in support of Petitioners, pursuant to Rule 42(2) of this Court.*

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* *See* Letter to Mr. Rodak from counsel for Petitioners and Respondents (April 10, 1978).

INTEREST OF AMICUS

The Motor Vehicle Manufacturers Association of the United States, Inc. ("MVMA") is a voluntary, nonprofit membership association composed of companies engaged in the production of motor vehicles in the United States.[1] MVMA's member companies employ in excess of 900,000 workers, the majority of whom are represented by the United Auto Workers and other unions.[2] Each member company provides comprehensive group health insurance benefits to its employees. These plans typically cover hospital care, medical care, dental care, vision care and hearing care, as well as the cost of prescription drugs. Premiums for this health insurance approach two billion dollars.

These group health insurance plans usually contain provisions requiring that the insurer contract in advance with providers of health care to furnish services to the insured employees. These arrangements are a result of collective bargaining, and they provide employees with greater risk coverage and insurance benefits than could otherwise have been available. Indeed, the Blue Shield of Texas drug insurance policy involved in this case was first issued as a result of a collective bargaining agreement between certain MVMA members and the United Auto Workers.

The Court of Appeals for the Fifth Circuit has decided that contractual arrangements with health pro-

[1] The member companies of MVMA are: American Motors Corporation, Checker Motors Corporation, Chrysler Corporation, Ford Motor Company, Freightliner Corporation, General Motors Corporation, International Harvester Company, PACCAR, Inc., The Nolan Company, Walter Motor Truck Company, White Motor Corporation.

[2] These employees share MVMA's interest in this case. This interest is presented in the *amicus* brief filed by the United Auto Workers and the AFL-CIO.

viders are not part of the business of insurance. The court's decision places in jeopardy a long-standing system of regulation applicable to these health insurance programs. It touches upon insurance coverages which employees have obtained through the collective bargaining process. It threatens the stability of one of the few effective means available to the companies and their employees to control rapidly rising health insurance costs.

These matters vitally concern MVMA's member companies. They have a direct interest in their employees' health needs and bargaining demands for health insurance; health care provisions are significant factors in employee performance and industrial stability.[3] Moreover, since the companies pay a large part of the premiums for health insurance, they have a direct interest in the efficiency of delivery systems for medical care and payment.

SUMMARY OF ARGUMENT

Contractual arrangements between insurers and providers of health services and prescription drugs are a traditional form of health insurance and a common and widespread feature of insurance plans and policies. Such arrangements afford a distinct form of protection to the insured against specific risks. Thus, they are central to the insurer-insured relationship. Moreover, these contractual arrangements serve another function recognized by this Court to be at the core of the "business of insurance"—the control of the cost of insurance. For these reasons, both insured employees and their employers have demanded provisions in their insurance plans requiring the insurer to enter into such arrangements.

[3] Proposed changes in health and pension provisions were significant causes of the recent prolonged strike in the coal industry. *See* Board of Inquiry, *Report to the President on Labor Disputes Affecting the Bituminous Coal Industry in the United States* (March 9, 1978).

These arrangements are, in fact, one of the few effective means to control rapidly rising health care costs. The federal and state governments, under Medicare and Medicaid programs, use the same arrangements. Many state regulators are now emphasizing that the arrangements be employed in order to keep insurance protection available at reasonable rates.

In the light of the widespread recognition of the essential role of these arrangements in the provision of health insurance protection, it makes no sense to hold that such common practices are not part of the "business of insurance," and Congress could not have intended such a result. As this Court has held, where a practice intimately affects both the type of insurance protection available to the insured and the cost of such protection, Congress determined that the public policy interests embodied in state regulation of the practice outweigh the policy interests expressed in the antitrust laws. Of course, if an insurance practice constitutes an "act of boycott, coercion, or intimidation," or if there is no state regulation of the practice, Congress has given primacy to the policies of the antitrust laws. But the Fifth Circuit held that the arrangements involved in this case do not constitute the "business of insurance" and, thus, are *never* exempted from the antitrust laws. This holding is contrary to all prior decisions on the point. It substitutes, for the certainty required to establish effective risk protection and cost control, the vagaries of case-by-case antitrust litigation. It undermines effective state regulation of the costs of insurance, frustrates the purposes of the McCarran-Ferguson Act, and upsets a well-established and increasingly necessary means by which companies can provide their employees with adequate health protection.

ARGUMENT

Introduction

In 1945, in response to this Court's decision in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), Congress enacted the McCarran-Ferguson Act, which exempted the "business of insurance" from application of the antitrust laws, where that business is regulated by state law.[4] In *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the Court considered the scope of this "business of insurance" exemption. While recognizing that the Act did not purport to exempt "all the activities of insurance *companies*," *id.* at 459 (original emphasis), the Court recognized that activities dealing with control over "the relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement" —specifically including rate regulation—were at the core of the business of insurance.[5]

The contractual arrangements at issue in this case not only affect the specific terms and type of insurance available but also are vital to the provision of health insurance at reasonable rates. They are thus central to the "business of insurance."

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[4] 15 U.S.C. §§ 1011-15 (1970). The exemption does not apply to "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." 15 U.S.C. § 1013(b).

[5] 393 U.S. at 460.

I. Contractual Arrangements with Providers of Health Care Are Central to the Relationship Between Insurer and Insured.

A. *Such Arrangements Are a Traditional Form of Health Insurance.*

Prepaid insurance protection, which requires contractual arrangements with providers of health care, has been a traditional form of health insurance. As is pointed out by *amicus* National Association of Insurance Commissioners, Blue Cross/Blue Shield has offered prepaid protection of this sort since its inception in 1939. Such arrangements have been subject to regulation by state insurance departments since that time.[6] Member com-

[6] *See* 1939 N.Y. Laws (Insurance) § 254 (codified at N.Y. Insurance Law (McKinney 1966) § 254). The traditional use of such contractual arrangements in the health insurance business was forcefully called to Congress's attention at the time it considered the legislation which subsequently became the McCarran-Ferguson Act. Attorney General Biddle, testifying in opposition to the Act, indicated that he had authorized the bringing of *South-Eastern Underwriters* because of his belief that the Supreme Court's then-recent decision in *American Medical Assn.* v. *United States*, 317 U.S. 519 (1943), subjected the business of insurance to the antitrust laws. In doing so, he aptly characterized health prepayment plans, with attendant provider contracts, as the essence of the insurance business:

> "Since the decision of the Supreme Court in *American Medical Association* v. *United States* . . . , it is manifest that insurance is trade or commerce—remember, that was the question in these cases following *Paul* v. *Virginia*—within the provisions of section 3 of the Sherman Act. That case involved a conspiracy against Group Health, in its essence indistinguishable from insurance although not formally so termed. The court said:
>
> > 'Group health is a membership corporation engaged in business or trade. *Its corporate activity is the consummation of the cooperative effort of its members to obtain for themselves and their families, medical service and hospitalization on a risk-sharing prepayment basis.*'

[Footnote continued on page 7]

panies of MVMA have purchased such protection for their employees at least since 1950, when they entered into collective bargaining agreements with the UAW providing for such benefits.

As the Brief for Petitioners demonstrates in detail, these arrangements have been uniformly considered to be part of the "business of insurance" by each circuit and district court that has considered the question, until the decision of the Fifth Circuit in this case. Although the decision below concerns directly only contracts between insurers and pharmacies, it threatens the historical use of such contracts across the entire spectrum of health insurance.

B. *The Arrangements Are Called for by the Contract of Insurance, and Provide Distinct Risk Protection to the Insured.*

Under the agreements at issue in this case, various "participating pharmacies" accept an insurance policy's deductible amount as full payment from the insured for covered drugs, and look to the insurer (Petitioner Blue Shield) for reimbursement for the remainder of their charge. The Fifth Circuit held that such agreements were not related to the insurer's obligation to its insureds, and thus did not constitute "the business of insurance." In the Fifth Circuit's view, the agreements

[6] [Continued]

> *"This definition fits but one word, and that perfectly. The word is 'insurance.'* Continuing, the court said:
>
> > 'The corporation collects its funds from members. *With these funds physicians are employed and hospitalization procured on behalf of members and their dependents.* The fact that it is cooperative and procures service and facilities on behalf of its members only, does not remove its activities from the sphere of business.' "

Joint Hearings Before the Subcommittees of the House and Senate Committees on the Judiciary on S.1362, H.R.3269 and H.R.3270, 78th Cong., 1st Sess., 41-42 (1943) (emphasis added).

were designed for the sole purpose of strengthening the financial condition of the insurer "by minimizing costs and maximizing profits." (App. 126a.)

But the Fifth Circuit ignored the fact that the insurance policy itself—the "contract of insurance"—by its terms obligates the insurer to contract with participating pharmacies to secure these particular arrangements.[7] Substantially identical provisions appear throughout prescription drug insurance plans purchased by MVMA's member companies for their employees. Provisions requiring arrangements with providers appear in the members' plans providing, *inter alia*, hospitalization, medical care, vision care, dental care and hearing aid benefits. The companies purchase such coverage not only from Blue Cross/Blue Shield, but also from a number of other insurance carriers.[8]

Such provisions meet the specific insurance needs of the insured employees and their employers. The nature of the protection afforded an insured by these provisions can best be seen from the existing alternative in the present case—the risks and inconvenience of dealing with a non-participating provider. When the insured purchases drugs from a non-participating pharmacy, he must pay the entire amount charged by the pharmacy and subsequently seek reimbursement from the insurer. Moreover, the insurer will only reimburse the insured for a fixed percentage of his expenses in excess of the plan's deductible amount.[9] Thus, the employee is uninsured for a portion of the amount charged. There is no ceiling on these potential uninsured expenses, since there is no limit

[7] *See* App. 57a.

[8] Carriers providing such coverage include, *inter alia*, Aetna Life and Casualty Insurance Company, John Hancock Mutual Life Insurance Company, Lincoln National Life Insurance Company, and Metropolitan Life Insurance Company.

[9] *See* App. 57a.

on his potential need for various drugs. In addition, the insurer's agreement to reimburse the insured for a portion of the *usual and customary* charge for a particular drug in excess of the deductible amount leaves the insured liable for *100%* of any charges in excess of what is usual and customary. Thus, the insured is vulnerable to overcharging by a pharmacist.

The risks of unlimited expenses and overcharging by hospitals, doctors and other providers of health care are particularly acute throughout the health field. First, the insured's need for health services is often immediate and crucial. Second, that need is not determined by the patient himself.[10] Third, comparative price information is limited. For these reasons, protection against these risks is of particular value to insureds in the health insurance area.

Policy provisions for contractual arrangements between the insurer and the provider of health care clearly protect the insured against both the risk of having to bear a portion of his potential medical expenses and the risk of overcharging. The availability of "participating" pharmacies, physicians and other providers essentially protects the insured against *any* cost in excess of the deductible amount—protection which he might not otherwise be able to obtain at all, and which he certainly could not obtain at a comparable cost.[11] As this Court has noted, the "underwriting of risks" is the essence of the business of insurance. *See SEC* v. *Variable Annuity*

[10] "The physician's diagnosis determines the extent to which his or her own services are required as well as the utilization of diagnostic tests, therapeutic drugs, and hospitals. The patient usually lacks sufficient information or expertise, even if so inclined, to question a physician's recommendation or to seek possible alternatives." Council on Wage and Price Stability, *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?* 85 (1976) (hereinafter cited as "CWPS").

[11] *See* Part II.A., *infra*.

Life Insurance Co., 359 U.S. 65, 73 (1959). The provision at issue provides distinct additional risk protection to the insured, and is central to the insurer-insured relationship.

C. *The Contractual Arrangements Reflect the Expressed Desires of the Insured.*

The insurer's obligation to contract with providers of health goods and services confers a distinct benefit of considerable value and importance to insureds and their employers, and they have specifically sought such provisions.[12]

This is demonstrated by the experience of the member companies of MVMA. Group health benefits, like most other elements of the employer-employee relationships common to MVMA members, have long been part of the collective bargaining process between companies and the unions representing their employees. Specific provisions regarding prescription drugs have been included, at the unions' insistence, in the companies' collective bargaining agreements for more than a decade. The United Auto Workers demanded prescription drug coverage in contract negotiations at least as early as 1964, and specific prescription drug benefits were actually agreed upon for the first time by the UAW and Ford in 1967.

In bargaining for a drug insurance plan, the company and the union negotiated the terms of each element of the proposed plan. The type of drugs covered, methods of benefit payment, controls to limit premium costs, and various exclusions were all negotiated and incorporated in the final contract between the parties. The specific question of whether the plan should include contractual

[12] Approximately 80% of health insurance premiums are paid through employment-related group insurance plans such as those maintained by MVMA's member companies for their employees. (*See* CWPS at 84.) In these plans, the employees are the insureds, but the employer pays all or part of the premiums.

arrangements between the insurer and "participating pharmacies," or should instead provide for reimbursement of the insured employees for a portion of "usual and customary" charges, regardless of the pharmacy chosen, was also negotiated. While the parties recognized certain other advantages and disadvantages to each method of payment, the extra protection of the "participating pharmacy" plan was agreed to and made a part of the collective bargaining agreement.

The resulting agreement, which became standard in the motor vehicle industry, provided that the companies would make arrangements with insurance carriers to provide prescription drug expense benefits, with a deductible amount of two dollars for each separate prescription order and refill, under which "Participating Providers" would accept a two dollar payment from the insured employees, and be reimbursed by the insurer for its acquisition cost plus a dispensing fee. Insured employees obtaining drugs from a non-participating provider would be reimbursed for 75% of the pharmacy's "usual and customary charges" in excess of the deductible amount.

These provisions for arrangements with pharmacies, worked out in the collective bargaining process, were incorporated into the contracts of insurance. This history is neither unique to the particular prescription drug provisions at issue in this case, nor to the auto industry. As a result of the collective bargaining process, similar provisions require contractual arrangements in hospitalization, vision care, dental care, and hearing aid plans purchased by MVMA's members. Employees in other industries have also sought out, through the collective bargaining process, a wide variety of prospective reimbursement programs in all areas of health benefits.[13] The fact that

[13] For example, the United Federation of Teachers contracts with pharmacists and providers of optical care, and its insurers contract with "participating" dentists to provide its members with benefits

the insured employees—and the employers bearing all or part of the cost of the plans—have themselves specifically demanded provisions for arrangements between carriers and health providers demonstrates that such arrangements are central to the insured-insurer relationship and, thus, to the "business of insurance." The court below was simply wrong in concluding that Blue Shield's contractual agreements with "participating pharmacies" were of no concern to the insureds or their employers.

II. The Cost-Containment Function Performed by Contractual Arrangements with Providers of Health Care Is a Vital Part of the "Business of Insurance."

As Judge McGowan, writing for the United States Court of Appeals for the District of Columbia Circuit, has emphasized, the very fact that particular activities and methods of reimbursing insureds directly and substantially affect the cost of a particular level of insurance protection constitutes a "persuasive indication that the activities are part of the business of insurance":

> "Of central significance in this entire context is the close relationship between the cost of reimbursing damage claims, on the one hand, and the insurance rates charged by appellees, on the other. Any doubt as to whether these activities should be deemed to fall within the business of insurance is ponderably eased by that economic reality." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262, 268-69 (D.C. Cir. 1977), *petition for cert. filed*, 46 U.S.L.W. 3375 (U.S. Dec. 6, 1977) (No. 77-580) (footnote omitted).

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similar to those negotiated in the motor vehicle industry. Similar coverage is provided to, *inter alia*, steelworkers, mineworkers and retail clerks. *See generally* Council on Wage and Price Stability, *Labor-Management Innovations in Controlling Cost of Employee Health Care Benefits*, 41 Fed. Reg. 40297 (Sept. 17, 1976) (reprinted in CWPS at 97).

Contractual arrangements such as those at issue in this case not only directly affect insurance rates, but are critical to making health insurance available at affordable rates.

A. *Contractual Arrangements with Providers Are Vital to Cost Containment in Health Insurance.*

The validity of the "economic reality" described by Judge McGowan—that rates are affected by the costs of reimbursement—is reinforced in the case of health insurance by a second economic phenomenon. The pervasiveness of health insurance in our society itself increases the costs of health goods and services, and, hence, the costs of reimbursement:

> "Rising health care costs, often propelled by excessive utilization of facilities and by a tendency to overinvest in high-technology equipment, have in many cases not been translated directly into higher prices for the consumer. Most patients have some form of insurance which lessens the burden of comparing the value of care with its price. Rising costs simply get translated into higher premiums in subsequent years, but not into prices confronting the consumer at the point of purchase of health care services. In addition, many providers are reimbursed by insurers on a retrospective basis, thus providing little incentive for efficiency in managing scarce resources." [14]

This phenomenon has intensified the crisis of rising costs of medical care. In these circumstances, the insurer must either pass on spiraling costs to policyholders, or he must find some way of minimizing the costs of the insured services through arrangements with providers. Insurance premiums have already reached excessive levels, and insurance carriers and employers have sought to

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[14] CWPS at 10.

control excessive use of insured services by imposing a percentage of the costs for the services used on the insured employees.[15] Coinsurance of this type is included in the plan at issue in this case as an alternative method of cost containment where drugs are purchased from a non-participating pharmacy.[16] Another method of discouraging excessive use of services, adopted in some policies, is to exclude from coverage "some ancillary services which may be highly elective, 'such as cosmetic surgery, dental and optical care.'" [17]

However, unions, in negotiating health benefits, have resisted plans which require coinsurance or other cost-sharing procedures.[18] Moreover, while coinsurance is useful in discouraging excessive and unnecessary use of health services, many health services are not "elective." Demand for such essential health services is inelastic, and coinsurance can only control the escalating costs of these services to a limited degree. For these reasons, both companies and unions have sought alternative means to contain rising costs.

The most effective alternative to restricting or discouraging the use of insured goods and services is instituting cost-containment measures which affect providers of medical services. That is the general course which has been taken in the auto industry. Thus, the health insurance benefits agreements negotiated between MVMA's

[15] As the Council on Wage and Price Stability reported, in summarizing hearings on the problem of rising health care costs, "Several companies indicated they would retain deductibles and coinsurance in their health benefit program in order to provide consumer incentives not to overutilize services." CWPS at 26.

[16] *See* pp. 8-9, *supra.*

[17] CWPS at 26.

[18] "Testimony from union officials indicated almost unanimous opposition to the reintroduction of copayment in health benefit plans." *Id.*

members and the UAW require the carriers to take extensive measures to control the cost of health services provided. The carriers are required, in addition to contracting with providers, to take numerous cost-control steps which directly affect providers. Such measures include pretreatment estimates of fees, peer reviews, price reviews, post-treatment evaluations, and utilization reviews.

As the Council on Wage and Price Stability's report on rising health care costs makes clear, all of these measures are used in various combinations virtually throughout the insurance industry, and are demanded by insured employees and their employers, in order to contain costs.[19] But, as the Council found, because such measures are dependent upon the voluntary cooperation of providers—in most cases, after the service has been provided—they are not nearly as effective as direct, contractual arrangements between insurers and providers in controlling medical costs.[20] Therefore, employers and employees in the auto industry have insisted on provisions for such arrangements in their health insurance plans.

It is, no doubt, for similar reasons that the federal government, in the programs where it serves as a health insurer, relies extensively on contractual arrangements with providers of health care. For example, Medicare regulations prohibit participating providers from charging Medicare customers an amount greater than an established reimbursable fee.[21] Similarly, participation in

[19] *See* CWPS at 23-31.

[20] "Several witnesses at the hearings testified that their efforts to increase involvement in cost control programs, even where they were just requests for information, were met by provider resistance." *Id.* at 24. On the other hand, the Council found that contractual arrangements can significantly reduce the costs of prescription drugs. *Id.* at 119.

[21] *See* 20 C.F.R. § 405.433(a)(4) (1977).

Medicaid is "limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure." [22] And the government's military dependent health insurance regulations provide for contractual arrangements with participating pharmacies, which must agree to accept the "actual acquisition cost of ingredients plus an established professional fee" as full payment from the insured.[23]

The contractual arrangements at issue in this case were implemented by the carriers to meet the health care cost crisis head-on. Such cost-containment arrangements and mechanisms are essential to controlling spiraling health care costs, which otherwise would result in constantly increasing insurance premiums or direct charges to the insured. This direct and significant interrelationship with the cost of insurance makes such arrangements central to the interests determined by Congress to be reserved for state regulation of the "business of insurance."

B. *Cost Control Is Part of the "Business of Insurance" for Which State Regulation Is Appropriate.*

By exempting the "business of insurance" from application of the antitrust laws only "to the extent that such business is . . . regulated by State law," [24] Congress obviously did not mean to free the insurance industry from all regulation, on the premise that the political and economic theories embodied in the antitrust laws do not apply to the business of insurance. Rather, Congress recognized that the business of insurance has a special impact on the public, and that specific policy concerns embodied in state regulation may supersede the more general policies of the antitrust laws in this sector of the economy.

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[22] *See* 45 C.F.R. § 250.30(a)(8) (1976).

[23] *See* 32 C.F.R. § 577.64(a)(4) and (h)(4) (1977).

[24] 15 U.S.C. § 1012(b) (1970).

In enacting the McCarran-Ferguson Act, Congress specifically recognized the validity of this Court's holding in *Osborn* v. *Ozlin*, 310 U.S. 53 (1940), that the states must be permitted to regulate insurance effectively.[25] As Mr. Justice Frankfurter noted:

> "Government has always had a special relation to insurance. The ways of safeguarding against the untoward manifestations of nature and other vicissitudes of life have long been withdrawn from the benefits and caprices of free competition." 310 U.S. at 65.

Congress clearly saw that effective regulation of insurance could conflict with antitrust policies, and opted for effective regulation.[26]

This Court made clear, in *SEC* v. *National Securities, Inc.*, *supra*, that among the policy interests which may, if embodied in state regulation, supersede the antitrust laws are not only the protection of the insurance companies' viability, but also—and primarily—"the interests of those purchasing insurance policies." [27] Congress clearly recognized that an important task of state regulation of

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[25] *See* S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944); H.R. Rep. No. 873, 78th Cong., 1st Sess. 8 (1943).

[26] As one commentator has noted,

> "Except for boycott, coercion, and intimidation, any act repugnant to the federal antitrust laws may be authorized by the state so long as public regulation is provided. This is a basic fact which should not be avoided apologetically as something vaguely wrong; it should be publicly stressed again and again, so that all may understand that every legislative body in the United States has determined that it is not in the public interest to have the Sherman Act apply to the business of insurance in the unqualified manner in which it affects the ordinary industry." Donovan, *Regulation of Insurance Under the McCarran Act*, 15 L. & Contemp. Prob. 473, 490 (1950).

[27] 393 U.S. at 460. Congress specifically intended that states enact regulatory schemes which would "consider the welfare of policyholders." H.R. Rep. No. 143, 79th Cong., 1st Sess. 4 (1945).

insurance was "preventing excessive charges to the public." [28]

Arrangements between insurers and providers of health care play a crucial role in preventing excessive rates. Contracts between insurers and providers are already subject to regulation in a large number of states, and state officials are increasingly focusing on such arrangements as a means of cost containment.[29] The former Insurance Commissioner of Pennsylvania has, in fact, testified that it is *impossible* to assure adequate health insurance coverage at a reasonable cost without such regulation:

> "[W]e think that these two items, the contract with the hospitals and the rates to the subscribers are part of the same package *and we have to regulate both of them together* or that we cannot provide health delivery to the public at the most reasonable cost possible." [30]

Indeed, the states are increasingly turning to *direct* regulation of the rates charged by providers of health services, and "[s]everal states have initiated hospital rate regulation . . . ." [31]

Arrangements with health care providers such as those involved here are consistent with the antitrust laws. Even if they were not, the state's interest in facilitating and regulating them would be thwarted by subjecting

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[28] 90 Cong. Rec. 6527 (1944) (remarks of Rep. Miller).

[29] *See* Brief for National Association of Insurance Commissioners for a comprehensive discussion of the present scope and nature of such state regulation. In the present case, the District Court specifically found that "[t]he State of Texas has actively regulated the activities challenged in Plaintiff's Complaint since the inception of Blue Shield's prescription drug insurance program." (App. 109a.)

[30] Cited in *Travelers Ins. Co.* v. *Blue Cross*, 481 F.2d 80, 83 n.9 (3d Cir. 1973) (emphasis added).

[31] CWPS at 39.

them to antitrust challenges. Contractual arrangements substantially the same as those at issue in this case have, on several occasions, received business review clearance by the Department of Justice.[32] Yet, as in this case, private parties have nevertheless subjected persons attempting to implement these cost-control measures to the uncertainties, expenses and delays of private antitrust litigation. The threat of such litigation not only delays implementation of wholly legal and desirable arrangements, but may effectively deter their future development and improvement, notwithstanding the expressed interest of the states in such programs and the benefits they provide to the public. To subject each cost-containment innovation involving providers of health care to *ad hoc*, case-by-case examination—with potentially different results in different courts—would make meaningful regulation of health insurance difficult, if not impossible.

Congress meant to exempt from the antitrust laws those insurance practices which are subject to state regulation in the public interest. That exemption does not apply to coercion, boycott or intimidation. Beyond this, however, the public policy issue has been determined. The availability of health insurance coverage at reasonable rates is intimately a part of the business of insurance. If there is a conflict with antitrust policy, Congress has decided that the interest of the public in regulation of health care insurance should prevail. The Fifth Circuit's decision contravenes that interest. It interferes with the ability of the states to control rates and types of coverage. It will produce higher premiums and reduced risk protection. Congress, in exempting "the business of insurance" from the antitrust laws, did not and could not have intended such a result.

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[32] *See, e.g.*, Letter from Assistant Att'y Gen. Donald F. Turner to Gerald L. Goodell, Esq. (Jan. 15, 1968), reproduced as Appendix C to Amicus Curiae Brief of Blue Shield Association in support of petition for certiorari.

CONCLUSION

For the reasons stated above, the decision below should be reversed.

Respectfully submitted,

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